STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	153510	A. BUILDING _____ B. WING _____	R 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH RENAL SERVICES	**550 N UNIVERSITY BLVD RM 1115 INDIANAPOLIS, IN 46202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This was a revisit for a federal ESRD recertification survey conducted 9/23/13 which resulted in citations at the Condition level. Survey Date: 11/6/13 Facility #: 005134 Provider #: 153510 Medicaid vendor #: 200119790A Surveyor: Bridget Boston, RN, PHNS During this survey, it was determined three Conditions for Coverage and twenty-six standard level deficiencies were found corrected. Indiana University Health Renal Services was in compliance with the Condtions for Coverage 42 CFR Part 494. Quality Review: Joyce Elder, MSN, BSN, RN November 7, 2013	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.